BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of

HARA P. MISRA, M.D.

Holder of License No. **14933**
For the Practice of Allopathic Medicine
In the State of Arizona.

Board Case No. MD-02-0749A

FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER

(Decree of Censure & Probation)

The Arizona Medical Board ("Board") considered this matter at its public meeting on April 14, 2005. Hara P. Misra, M.D., ("Respondent") appeared before the Board with legal counsel Michael Bradford for a formal interview pursuant to the authority vested in the Board by A.R.S. § 32-1451(H). The Board previously conducted a formal interview involving case number MD-02-0749A at its August 2004 meeting. At the conclusion of that interview, the Board continued the investigation and requested an outside medical consultant be retained to review the case, including the transcript from the interview. That review was completed and the case returned to the Board. The Board voted to issue the following findings of fact, conclusions of law and order after due consideration of the facts and law applicable to this matter.

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of License No. 14933 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-02-0749A after receiving notification from Scottsdale Healthcare that Respondent had resigned staff privileges at Scottsdale Healthcare Shea pending an investigation into the quality of care he provided to patients.

4. A 54 year-old female patient ("CM") was admitted to the hospital approximately six days after undergoing spinal surgery. CM was found to have a significant deep vein thrombosis in her left leg. The thrombosis extended into the iliac veins and was documented by ultrasound. Respondent was consulted and decided to proceed that evening with the placement of a Greenfield filter ("Filter"). While placing the Filter Respondent noted that it failed to properly deploy and migrated up the vena cava. The Filter has hooks on its end designed to engage the vena cava and maintain it in the position where it filters out large clots and protects the heart. Respondent also noted that when the Filter traversed toward the heart up the vena cava the anesthesiologist reported a few extra beats that subsided.

5. Respondent then placed a second Filter. This Filter maintained its position and CM was later admitted to Intensive Care. The following day, sometime around mid-morning, CM began to have runs of ventricular tachycardia – a serious arrhythmia that was immediately addressed by a call to the cardiologist. The cardiologist instituted an echocardiogram to locate the position of the foreign body, the Filter, in the heart. An interventional radiologist then unsuccessfully attempted to retrieve the Filter. A cardiac surgeon was then called. CM was further evaluated for coronary disease and was taken to surgery that evening where open heart surgery was required to remove the Filter from the right ventricle and the outflow track of the right ventricle. Some valvular damage caused by the Filter was also repaired. CM then had a recovery consistent with the open heart surgery she had been subjected to.

6. Respondent testified he performed a Filter placement in CM to prevent pulmonary embolism, an invariably fatal complication with concurrent anticoagulation with Lovenox and Coumadin. Respondent testified he used due precaution in placing the Filter under fluoroscopy, but the first Filter migrated to the right atrium. Respondent

noted there were no cardiac dysrhythmias or any change in CM's vital signs. Respondent testified he immediately placed a second Filter without any complication or untoward incident. Respondent testified that he was with CM within 15 minutes of the dysrhythmia developing and arranged for the cardiac consult, subsequent radiological consult and the cardiosurgical interventions that were done at the soonest possible time.

7. Respondent testified he was present from early morning until late night when the cardiac surgery was completed. Respondent noted he was with family members and had discussions with the radiologist, internist and cardiac surgeons throughout the day. Respondent stated he followed CM every day thereafter until her discharge from the hospital and in his office after that. Respondent testified he submitted literature for the Board's review and there is not a single article that tells a physician to intervene to remove the right-sided heart foreign body without a significant cardiac dysrhythmia or change of the patient's vital signs.

8. Respondent was asked if he used any method of measurement such as an ultrasound or a venogram to make sure of the size of the Filter before it was put into position. Respondent testified he did not and only does so in certain circumstances, not in a routine Filter placement. Respondent was asked to identify the optimal placement of the Filter. Respondent testified it was between level 2 and level 4 in the lumbar region, below the renal vein. Respondent was asked how he knew he was below the renal vein without doing any type of study. Respondent testified that renal vein position is fairly consistent in normal patients and placement above the renal vein is also not detrimental to the prevention of pulmonary embolism.

9. Respondent was asked why he wanted to place the Filter below the renal veins. Respondent testified he did so because in case the thrombus is caught in the Filter and it is below the renal vein there will be no compromise of the venal circulation of

the renal veins. Respondent was asked if knowing the L3 or L2 or L4 can vary depending on whether or not there was five or six lumbar vertebra and knowing he wants to place it in the preferred position below the renal veins would it not make sense to try to do something to ensure he always had it in the right place. Respondent agreed, but noted he had used fluoroscopy to confirm the Filter location in CM and she had five lumbar vertebra and the position of the Filter is placed below lumbar two and he confirmed that by putting the second filter. Respondent testified if a patient is very obese, or has other side leg edema, or other congenital anomalies, or a known problem with some other intra-abdominal conditions then the IV position and the vertebral terms of the renal vein will be different from the norm and he would do the venogram.

10. Respondent was asked what his long term plan would have been for CM if she had remained asymptomatic. Respondent testified he would leave the decision whether to leave or remove the Filter to other attending physicians. Respondent was asked if he spoke with CM's internist after the surgery. Respondent testified he did. Respondent was asked about a progress note made by the internist where the impression was "left lower extremity DVT, status placement renal filter stable." The note went on to say "migraine headache, stable. Discharge tomorrow afternoon." The Board noted that from this progress note it appears the internist was not aware there was a misplacement of the initial Filter. Respondent referred the Board to a letter written on Respondent's behalf by the internist. The letter states that Respondent discussed the problem with the Filter with him immediately after surgery and Respondent insisted CM be kept in the intensive care unit. The Board noted a disconnect between the internist letter, written some time after the surgery, and the internist's contemporaneous notes to suggest he was recommending CM go to the telemetry unit.

11. Respondent was asked about his operative note that there was "no operative complication, incidental first Greenfield filter did not open. Mechanical device problem. And open at the right pulmonary artery, minimal bleeding." Specifically, Respondent was asked if he felt it was not an operative complication to lose a Filter that migrated to the heart. Respondent testified his dictated operative report mentioned the incidental finding and in the description of the surgical procedure he noted there were no *other* operative complications. Respondent was asked what would happen in the case of an emergency with CM because the dictated operative note would not have been on the chart for some hours after the procedure and a responding physician would not know about the migrated Filter. Respondent testified that any attending reading the operative note would go on to read the next sentence that describes what happened. The Board noted the next sentence was difficult to read.

12. Respondent testified that 60% of the vascular surgeons dealing with a patient like CM do not use a venogram. Respondent also noted the position of the renal vein is not critical because in many instances the Filter can be placed, involving the venogram to protect them from thromboembolic phenomenon of acute traumas by avoiding thromboembolism. Respondent also noted that besides the point of unnecessary venograms, the surgeon avoids the complication of the venogram itself, which is a .5 to 5% chance of damage to the kidney function, 1 to 3% development of iodine dialysis, and a 1 to 10% chance of phlegmasia vena traumas at the site of the venogram from intubation of the vein itself from the iodine dye. Respondent testified that, overall if one looks at the picture, performing a venogram prior to Filter placement in CM's case is not wise. Respondent was asked what eventually happened with CM with respect to the tricuspid valve. Respondent noted CM developed tricuspid insufficiency and needed valve repair.

13. Respondent again testified that the position of the Filter in the right side of the heart is immaterial and can be left alone unless there are cardiac dysrhythmias. Respondent was asked if the Filter had migrated distally in the pulmonary arteries in one segment of the lung or pulmonary vessels distally would there be any obstruction in the distal portions of the pulmonary artery. Respondent testified none of the literature notes a filter in the pulmonary artery that has caused collapse of the lung and he feels there is no potential for that whatsoever. The Board noted the literature cited by Respondent mentions only a small number of cases of Filters being left in and asked Respondent what the literature speaks to in terms of the number of Filters that have been dislodged that have required extraction versus those that have been left in. Respondent stated he did not remember, but could produce the literature for the Board. Respondent noted his recollection was that 90% of the Filters are left in and only 10% retrieved.

14. Respondent was asked whether, since this was the first time migration of a Filter had occurred in his practice, it would have been prudent to immediately consult with internal medicine, cardiology or cardiovascular surgery to determine the best course of action rather than waiting 12, 24, or 36 hours to deal with the complication. Respondent testified he discussed what happened with the internist and decided to wait because there was not a change of vital signs.

15. The standard of care required Respondent to locate the exact position of the migration of the Filter.

16. Respondent deviated from the standard of care because he failed to locate the exact position of the migration of the Filter.

17. CM was harmed because her condition developed into an emergency situation when an arrhythmia was detected and she had to undergo open heart surgery to remove the Filter.

18. An aggravating factor in determining discipline is the previous two Letters of Reprimand issued by the Board to Respondent. A.R.S. § 32-1451(U).

CONCLUSIONS OF LAW

1. The Arizona Medical Board possesses jurisdiction over the subject matter hereof and over Respondent.

2. The Board has received substantial evidence supporting the Findings of Fact described above and said findings constitute unprofessional conduct or other grounds for the Board to take disciplinary action.

3. The conduct and circumstances described above constitutes unprofessional conduct pursuant to A.R.S. § 32-1401(27)(q) ("[a]ny conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.")

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law,

IT IS HEREBY ORDERED that

1. Respondent is issued a Decree of Censure for failure to properly manage the complication of a Greenfield Filter migrating to a patient's heart.

2. Respondent is placed on probation for two years subject to the following terms and conditions:

a. Respondent shall within one year of the effective date of this Order obtain 20 hours of Board Staff pre-approved Category I Continuing Medical Education ("CME") for the indications of placement of vena cava filters and shall provide Board Staff with satisfactory proof of attendance. The CME is in addition to the hours required for biennial renewal of medical license.

b. Board Staff or its agents shall conduct quarterly reviews of the charts of Respondent's surgical cases. The Board may take additional disciplinary or

remedial action based on the results of the chart reviews. Respondent shall be responsible for the costs of conducting the chart reviews. Such costs shall be paid within 60 days of Respondent being notified of the amount due.

RIGHT TO PETITION FOR REHEARING OR REVIEW

Respondent is hereby notified that he has the right to petition for a rehearing or review. The petition for rehearing or review must be filed with the Board's Executive Director within thirty (30) days after service of this Order. A.R.S. § 41-1092.09(B). The petition for rehearing or review must set forth legally sufficient reasons for granting a rehearing or review. A.A.C. R4-16-102. Service of this order is effective five (5) days after date of mailing. A.R.S. § 41-1092.09(C). If a petition for rehearing or review is not filed, the Board's Order becomes effective thirty-five (35) days after it is mailed to Respondent.

Respondent is further notified that the filing of a motion for rehearing or review is required to preserve any rights of appeal to the Superior Court.

DATED this 6 day of July, 2005.

THE ARIZONA MEDICAL BOARD

By for
TIMOTHY C. MILLER, J.D.
Executive Director

ORIGINAL of the foregoing filed this 7 day of July, 2005 with:

Arizona Medical Board
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258

Executed copy of the foregoing
mailed by U.S. Certified Mail this
7 day of July, 2005, to:

Michael Bradford
Bradford Law Offices, PLLC
4131 North 24th Street – Suite C-201
Phoenix, Arizona 85016-6256

Executed copy of the foregoing
mailed by U.S. Mail this
7 day of July, 2005, to:

Hara P. Misra, M.D.
Address of Record

Patricia Reynolds